License Verification

Data As Of 2/28/2012

MICHAEL J BENJAMIN

LICENSE NUMBER: ME14909

Profession

MEDICAL DOCTOR

License/Activity Status

CLEAR/ACTIVE

Qualifications

Dispensing Practitioner

License Expiration Date

1/31/2014

Discipline on File

YES

License Original Issue Date

12/31/1973

Public Complaint

YES

Address of Record

7777 N. UNIVERSITY DR SUITE 102 TAMARAC, FL 33321

The information on this page is a secure, primary source for license verification provided by The Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.

Active Medical Doctor License # ME 14909 expires January 31, 2006.

The fee of \$454.00 and the renewal notice must be postmarked on or before <u>January 31, 2006</u>. Renewal notices postmarked on or after <u>February 1, 2006</u> require renewal and delinquent fees of \$839.00.

This address will be used for all correspondence from the Department of Health.

This address will be printed on your license and posted on the internet.

MICHAEL J BENJAMIN 7707 N UNIVERSITY DR SUITE 205 TAMARAC, FL 33321 7707 N UNIVERSITY DR SUITE 205 TAMARAC, FL 33321

Go to <u>www.doh-maservices.com</u> to renew your license, change your address, and confirm information maintained by the Department. Listed below is your Account ID and password for online services. If you renew online, you will receive a temporary license upon successful completion of your renewal. Online renewals are processed immediately and your license status is updated online within seven business days.

Avoiding complaints can protect your clients and your ability to practice. Go to www.doh.state.fl.us/mga/avoid.html to find out more.

If you have any changes to the name, mailing address, practice location address, license status or military status information associated with your license, please provide the updated information in the appropriate fields of section 7 on the back of this form.

A. Online Renewal: Visit www.doh-mqaservices.com go to the Practitioner Logon box, select your profession and enter your Account ID and password. If you are requesting a status change, you will be ineligible to renew your license online. The system will be available for renewals until midnight, Eastern Standard Time (EST), January 31, 2006. To use the online system, you will need the following information:

Account ID:

Password .

(Note: Account ID and Password must be entered exactly as they appear.)

The online renewal system will allow practitioners to update their mailing address and to confirm licensee information maintained by the Department. Practitioners will receive confirmation of their successful renewal before logging out of the system.

B. <u>U.S. Mail:</u> Mail completed form and fee payable to the Department of Health to the following address: Department of Health, Division of Medical Quality Assurance, PO Box 6320, Taliahassee, FL 32314-6320

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

File Number: 10330 Profession Code: 1501 Sequence Number: 2721

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Florida Department of Health - Board of Medicine License Renewal Notice

Active (group 1) Medical Doctor License # ME 14909 expires January 31, 2002.

To avoid a delinquent charge, the fee of \$496.00 and the renewal form must be postmarked or electronically submitted on or before

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øAddr: 7707 N UNIVERSITY DR SUITE 205
                                        State:
                                               FL
                                        Zip:
                                               33321
øCity: TAMARAC
                                        County: BROWARD
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@Certificate No: P373622
        Date: 12/23/1997
                         In Rank Since: 12/31/1973
øLast Renewal:
                         License Method: EXEN
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Florida Department of Health - Board of Medicine LICENSE RENEWAL NOTICE

Active Medical Doctor License # ME 14909 expires January 31, 2006.

The fee of \$454.00 and the renewal notice must be postmarked on or before January 31, 2006. Renewal notices postmarked on or after February 1, 2006 require renewal and delinquent fees of hear Amount: \$454.00 \$839.00.

Deposit Date: 12/9/05 Deplesit # : 167169 Bate Number : 1011948 Valigation # : 905137382

Received Date: 12/2/05

PRO CDE: 1501

1. CURRENT MAILING ADDRESS:

This address will be used for all correspondence from the Department of Health.

MICHAEL J BENJAMIN 7707 N UNIVERSITY DR **SUITE 205** TAMARAC, FL 33321

2. CURRENT PRACTICE LOCATION:

This address will be printed on your license and posted on the internet.

7707 N UNIVERSITY DR **SUITE 205** TAMARAC, FL 33321

3. RENEW ON LINE TODAY!

Go to www.doh-masservices.com to renew your license, change your address, and confirm information maintained by the Department Listed below is your Account ID and password for online services. If you renew online, you will receive a temporary ticense upon successful completion of your renewal. Online renewals are processed immediately and your license status is updated online within seven business days.

Avoiding complaints can protect your clients and your ability to practice. Go to www.doh.state.fl.us/mga/avoid.html to find out

4. CHANGES TO CURRENT LICENSE INFORMATION:

If you have any changes to the name, mailing address, practice location address, license status or military status information associated with your license, please provide the updated information in the appropriate fields of section 7 on the back of this form.

5. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. Online Renewal: Visit www.doh-mgaservices.com go to the Practitioner Logon box, select your profession and enter your Account ID and password. If you are requesting a status change, you will be ineligible to renew your license online. The system will be available for renewals until midnight, Eastern Standard Time (EST), January 31, 2006. To use the online system, you will need the following information:

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B. U.S. Mail: Mail completed form and fee payable to the Department of Health to the following address: Department of Health, Division of Medical Quality Assurance, PO Box 6320, Tallahassee, FL 32314-6320

6. Other Information:

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

File Number: 10330

Sequence Number: 2721

Profession Code: 1501.

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Florida Department of Health - Board of Medicine LICENSE RENEWAL NOTICE

Active Medical Doctor License # ME 14909 expires January 31, 2004.

The fee of \$454.00 and the renewal notice must be postmarked on or before January 31, 2004. Renewal notices postmarked on or after February 1, 2004 require renewal and delinquent fees Ched Amount: \$454.00 \$839.00.

Received Date: 12/22/03 Deposit Date: 12/22/03 Deposit #: 187481 BatcleNumber: D11897

PRO_CDE : 1501

1. CURRENT MAILING ADDRESS:

This address will be used for all correspondence from the Department of Health.

MICHAEL J BENJAMIN 7707 N UNIVERSITY DR **SUITE 205** TAMARAC, FL 33321

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Online Renewal: Visit https://www.doh.state.fl.us/mqaservices and click on Renew My License to renew your license online. If you are requesting a status change you will be ineligible to renew your license online. The system will be available for renewals until midnight, Eastern Standard Time (EST), January 31, 2004. To use the online system, you will need the following information:

Account ID:

Password

(Note: Account in and Password are case sensitive.)

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U.S. Mail: Mail completed form and fee payable to the Department of Health to the following address:

Department of Health Division of Medical Quality Assurance PO Box 6320 Tallahassee, FL 32314-6320

6. Other Information:

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

File Number: 10330 Profession Code: 1501 Sequence Number: 480



Active Medical Doctor License # ME 14909 expires January 31, 2004.

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MICHAEL J BENJAMIN 7707 N UNIVERSITY DR SUITE 205 TAMARAC, FL 33321 This address will be printed on your license and posted on the Internet.

7707 N UNIVERSITY DR SUITE 205 TAMARAC, FL 33321

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(Note: Account id and Password are case sensitive.)

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B. <u>U.S. Mail:</u> Mail completed form and fee payable to the Department of Health to the following address:

Department of Health
Division of Medical Quality Assurance
PO Box 6320
Taliahassee, FL 32314-6320

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

File Number: 10330

Sequence Number: 458

Profession Code: 1501

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Active (group 1) Medical Doctor License # ME 14909 expires January 31, 2002.

File Number: 10330

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To avoid a delinquent charge, the fee of \$406.00 and the renewal form must be postmarked or electronically submitted on or before <u>January 31, 2002</u>. Renewal notices/forms postmarked on or after <u>February 1, 2002</u> require renewal and delinquency fees of \$791.00.

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DEPARTMENT OF PROFFSE ONAL AND OCCUPATIONAL REQULATION BOARD OF MEDICAL EXAMINERS

APPLICATION FOR CERTIFICATE OF ANNUAL REGISTRATION (Please Type or Print)

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Robert G. Brooks, M.D. Secretary

MICHAEL J BENJAMIN, M.D. 7707 N UNIVERSITY DR SUITE 205 TAMARAC, FL-33321

Dear Dr. BENJAMIN

The information to be published on your practitioner profile is printed below. In carrying out our legislative mandate to publish physician profiles, we want to do everything we can to ensure the information that is published is correct. We are providing this information to you prior to its publication to give you an opportunity to review the data for any changes, corrections, and/or omissions. Under Section 456.042, Florida Statutes, you have thirty (30) days from the date you receive this letter to submit changes to 4052 Bald Cypress Way, Bin # C10, Taliahasses, Florida 32399-3260. If you have no changes, your profile will be published as it appears below on the World Wide Web. Listed below is information that you should review carefully.

First, although the law requires you to report all disciplinary action taken by facilities, including facilities outside Florida, the action taken by Florida licensed hospitals and ambulatory surgical centers will not be published on the profile. Please review and identify and action, which was taken by a hospital or ambulatory surgical center licensed in Florida to ensure this discipline is not included on the published profile.

Second, the law requires that all criminal convictions must be reported to the department pursuant to Section 456.039(1)(a)7, Florida Statutes. If your criminal conviction was expunged or the records were sealed, please send a copy of the court order expunging or sealing the records. If you have any questions or concerns about the criminal corrections to be published on the profile, as they are stated in this letter, please provide them in writing to the department.

> My profiling information is correct My profiling information is incorrect; changes are noted below.

Practitioner Information

License Number: 14909

Profession : Medical Doctor

License Status

: ACTIVE CLEAR

Year Began Practicing: 07/01/1968

Primary Business:

7707 N UNIVERSITY DR SUITE 205

TAMARAC FL 33321

Secondary Locations:

Staff Privileges:

Institution Name
NORTHWEST MEDICAL CENTER
CORAL SPRINGS MEDICAL CENTER
UNIVERSITY MEDICAL CENTER

City State

MARGATE FLORIDA

CORAL SPRINGS FLORIDA

TAMARAC FLORIDA

Faculty Appointments:

This practitioner has not had the responsibility for graduate medical education within the last 10 years.

This practitioner does not currently hold faculty appointments at any medical/health related institutions of higher learning.

Participates in Medicaid Program:

No

il. Education and Training

Medical School: Dates of Attendance: Graduation Date: Degree Title

1. HEALTH SCI CENTER-BROOKLYN: 08/01/1963 - 05/01/1967: 05/01/1967: MD

Other Health Related Degrees:

This practitioner does not hold any additional health related degrees.

III. Professional and Postgraduaté Training

This practitioner has completed the following graduate medical education:

Program Name: Program Type: Specialty Area: City: State/Country: Dates Attended

1. LONG ISLAND JEWISH MEDICAL CENTER: INTERNSHIP: TY-TRANSITIONAL YEAR::

NEW YORK: 7/1/1967 - 6/30/1968

2. HOSPITAL CENTER: RESIDENCY: OBG - OBSTETRICS AND GYNECOLOGY:: NEW YORK

: 7/1/1989 - 6/30/1971

IV. Specialty

This practitioner holds the following certifications from specialty boards recognized by the Florida board which regulates the profession for which he/she is licensed:

Specialty Board : Certification

1, AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY: OBG - OBSTETRICS AND GYNECOLOGY

V. Optional information

Committees:/Memberships

This practitioner has an affiliation with the following committees:

1. QUALITY ASSURANCE COMMITTEE

Professional or Community Service Awards

This practitioner has not provided any professional or community service activities, honors, or awards.

Publications

This practitioner has not provided any publications that he/she authored in peer-reviewed medical literature within the last ten years.

4052 Bald Cypress Way, Bin # C10, Tallahassee, Florida 32399-3280

Languages Other Than English

This practitioner has indicated that the following languages other than English are used to communicate with patients, or that a translation service is available for patients, at his/her primary place of practice:

1. FRENCH

2. SPANISH

Other Affiliations

This practitioner has provided the following national, state, local, county, or professional affiliations:

1. AMERICAN COLLEGE OF OBSTETRICS & GYNECOLOGY
2. FLORIDA ACADEMY OF OBSTETRICS & GYNECOLOGY
3. BROWARD COUNTY MEDICAL ASSOCIATION

BOARD OF

E-Mail Address

Not Provided.

Other State Licensure

This practitioner has not indicated any additional state licensure.

Financial Responsibility

I have hospital staff privileges and I have professional l-ability coverage in an amount not less than \$250,000 per claim, with a minimum annual aggregate of not less than \$300,000 from an authorized insurer as defined under's. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under a. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.367, F. S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance, I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is terminated or that I desire to become uninsured and meet the financial responsibility requirement through other provisions in s. 458.320 or 459.0085, F. S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

Criminal Offenses

The criminal history information, if any exists, will be incomplete; federal criminal history is not available to the public. The criminal history information provided by the practitioner has not been completely verified at this time. All criminal history checks should be completed by March 2000.

This practitioner has indicated that he/she has NO criminal offenses.

Final Disciplinary Action (Within last 10 years)

Pursuant to section 455.5651(5), F.S. the profile will not include disciplinary action taken by a hospital or ambulatory surgical centers licensed under chapter 395, F.S.

AC#

DEPARTMENT OF HEALTH DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
12/04/2001	ME 14909	63229

THE MEDICAL DOCTOR
NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAMP AND BULES OF THE STATE OF FLORIDA

THE LAWS AND RULES OF THE STATE OF FLORIDA EXPIRATION DATE: JANUARY 31 2004 MICHAEL J BENJAMIN 7707 N UNIVERSITY BR

SUITE 206 TAMARAC, FL. 33321 OPY C

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AT LEAST 90 DAYS PRIOR TO THE EXPIRATION DATE SHOWN ON THIS LICENSE, A NOTICE OF RENEWAL WILL BE SENT TO YOUR LAST KNOWN ADDRESS. IF YOU HAVE NOT RECEIVED YOUR NOTICE 60 DAYS PRIOR TO THE EXPIRATION DATE, PLEASE CALL (850) 410-3359.

COPY - NOT A VALID LICENSE - COPY

EXPIRATION DATE: JANUARY 31, 2004
YOUR LICENSE NUMBER IS ME 14009 PLEASE USE IT IN ALL CORRESPONDENCE WITH YOUR BOARD/COUNCIL. EACH
LICENSEE IS SOLELY RESPONSIBLE FOR NOTIFYING THE DEPARTMENT IN WRITING OF THE LICENSEE'S CURRENT MAILING

LICENSEE IS SOLELY RESPONSIBLE FOR NOTIFYING THE DEPARTMENT IN WRITING OF THE LICENSEE'S CURRENT I ADDRESS, USE THIS SECTION TO REPORT NAME AND/OR MAILING ADDRESS CHANGES.

NAME CHANGES REQUIRE LEGAL DOCUMENTATION SHOWING THE NAME CHANGE. PLEASE MAKE SURE THAT A PHOTOCOPY OF ONE OF THE FOLLOWING ACCOMPANIES THIS FORM: A MARRIAGE LICENSE (MARRIAGE LICENSE MUST INDICATE THE ORIGINAL SIGNATURE AND SEAL FROM THE CLERK OF THE COURT), A DIVORCE DECREE INDICATING RESTORATION OF YOUR MAIDEN NAME, OR A COURT ORDER (E.G., ADOPTION, NAME CHANGE, OR FEDERAL IDENTITY CHANGE). ANY ONE OF THESE WILL BE ACCEPTED UNLESS THE DEPARTMENT HAS A QUESTION ABOUT THE AUTHENTICITY OF THE DOCUMENT. A DRIVER'S LICENSE OR SOCIAL SECURITY CARD IS NOT CONSIDERED LEGAL DOCUMENTATION.

TO REQUEST A DUPLICATE LICENSE SUBMIT THIS FORM AND A CHECK, PAYABLE TO THE DEPARTMENT OF HEALTH, IN THE AMOUNT OF \$25.00.

	REQUEST DUPLICATE LICENSE
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SIGNATURE REQUIRED

DEPARTMENT OF HEALTH DIVISION OF MEDICAL QUALITY ASSURANCE LICENSURE SERVICES 4062 BALD CYPRESS WAY, SIN #C-10 TALLAHASSEE, FLORIDA 32399-3260

N	AME CHANGE (AT	TACH LEGAL DOCUMEN	TATION)	MAILING	ADDRESS CHANGE	
FROM: .	MIDDLE					
TO: .	LAST	FIRST	MIDDLE	CITY	STATE	ZIP

DH 2103, 5/98

DEPARTMENT OF HEALTH DIVISION OF MEDICAL QUALITY ASSURANCE LICENSURE SERVICES 4062 BALD CYPRESS WAY, BIN #C-10 TALLAHASSEE, FLORIDA 32399-3260

> MICHAEL J BENJAMIN 7707 N UNIVERSITY DR SUITE 205 TAMARAC, FL 33321

7. CHANGES TO CURR	ENT LICENSE INFORMATION:	
CHANGE OF NAM		
following accompanies of the court), a divorce federal identity change	s this form: a marriage license (marria e decree indicating restoration of your	the change. Please make sure that a photocopy of one of the gelicense must indicate the original signature and seal from the cierlinaiden name, or a court order (e.g., adoption, name change, or whees the department has a question about the authenticity of the risidered legal documentation.
If the name change of	annot be completed, your license will t	e renewed using the current name.
Last Name:		
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FINANCIAL RESPONSIBILITY

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NAME:	LICENSE NUMBER:

Financial Responsibility options are divided into two categories, coverage and exemptions. <u>Choose only one option</u> of the ten provided pursuant to s. 458.320, Florida Statutes.

OPTION I: FINANCIAL RESPONSIBILITY COVERAGE

- ido not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than \$100,000 per claim, with a minimum annual aggregate of not less than \$300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 628.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.367, F.S.
- I have hospital staff privileges and I have professional liability coverage in an amount not less than \$250,000 per claim, with a minimum annual aggregate of not less than \$750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 625.914(2), F. S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self insurance as provided in s.627.357, F.S.
- I do not have hospital staff privileges and I have established an irrevocable letter of credit or an escrow account in an amount of \$100,000/\$300,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.
- 1 have hospital staff privileges and I have established an irrevocable letter of credit or an eacrow account in an amount of \$250,000/\$750,000, in accordance with Chapter 675, F. S., for a letter of credit and a. 625.52, F. S., for an eacrow account.



I have elected not to carry medical malpractice insurance, however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1 or 459.0085(5)(g)1, F. S. I understand that I must either post notice in the form of a "eign" prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g) or 459.0085(5)(g), F. S.

OPTION II: FINANCIAL RESPONSIBILITY EXEMPTIONS

- 1 practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions;
- 1 hold a limited license issued pursuant to s. 458.317 or 459.0075, F. S., and practice only under the scope of the limited license;
- I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).
- 14. I do not practice medicine in the State of Florida or.
- III.5. I meet all of the following criteria:
 - (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
 - (b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
 - (c) I have had no more than two claims resulting in an indemnity exceeding \$25,000 within the previous five-year period:
 - (d) I have not been convicted of or pled guilty or noto contendere to any criminal violation specified in Chapter 458 or 459, F.S.; and
 - (e) I have not been subject, within the past ten years of practice, to license revocation or suspension, probation for a period of three years or longer, or a fine of \$500 or more for a violation of Chapter 458 or 459, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license stipulation, consent order or other settlement offered in response to or in anticipation of filing of administrative charges against a license shall be construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in the form of a sign, prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided, that I have decided not to carry medical malpractice insurance. I understand such a sign or notice must contain the wording specified in s. 458.320(5)(f) or 459.0085(5)(f), F. S.

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MICHAEL J. Benjamin, Wd

FACOG

Division of Medical Ruduty Assurance Jallahassee, Fl 32314-6320 Dept. of Habsth PO BOX 6320

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207 norch university dr. * suite 205 12565 * Horids * 33321

FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions.

<u>Choose only ONE option</u> of the ten provided pursuant to s.458.320, Florida Statutes.

CATE	GORY I - CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:
O 1.	I do <u>not</u> have hospital staff privileges and I have established an irrevocable letter of credit or an escrow account in an amount of \$100,000/\$300,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.
O 2.	I have hospital staff privileges and I have established an irrevocable letter of credit or escrow account in an amount of \$250,000/\$750,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.
3 .	I do <u>not</u> have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than \$100,000 per claim, with a minimum annual aggregate of not less than \$300,000 from an authorized insurer as defined under s. 624.09, F. S., from a risk retention group as defined under s. 627.942, F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.367, F.S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance; I will purchase retroactive coverage for the two years proceeding my inception date of coverage. I further certify that in the event my coverage is terminated or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years precipiting my becoming uninsured.
Ø 4.	I have hospital staff privileges and I have professional liability coverage in an amount not less than \$250,000 per claim, with a minimum annual aggregate of not less than \$750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association astablished under s. 627.351(4), F. S., or through a plan of self insurance as provided in s. 627.367, F.S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is cancelled or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.
O 5.	I have elected not to carry medical malpractice insurance, however, I agree to satisfy any adverse judgements up to the minimum amounts pursuant to a. 458.320(5)(g)1 or 459.006S(5)(g)1, F. S. I understand that I must either post notice in the form of a "sign" prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g) or 459.006S(5)(g), F. S.
CATE	GORY II - EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:
○6.	I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions:
107.	I hold a limited license lesued pursuant to s. 458.317 or 459.0075, F. S., and practice only under the scope of the limited license;
	I hold a limited license lesued pursuant to s. 458.317 or 459.0075, F. S., and practice only under the scope of the limited license; I do not practice medicine in the State of Florida;
О в.	
О в.	I do not practice medicine in the State of Florida;
О в.	I do not practice medicine in the State of Florida; I meet all of the following criteria:
О в.	I do not practice medicine in the State of Florida; I meet all of the following criteria: (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
О в.	I do not practice medicine in the State of Florida; I meet all of the following criteria: (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years; (b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
О в.	I do not practice medicine in the State of Florida; I meet all of the following criteria: (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years; (b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year; (c) I have had no more than two claims resulting in an indemnity exceeding \$10,000 within the previous five year period; (d) I have not been convicted of or pled guilty or noto contenders to any criminal violation specified in Chapter 458 or 459,

MICHAEL BENJAMIN, M.D. 7707 N. UNIVERSITY DR. #205 TAMARAC, FL. 38521

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DIVISION OF MEDICAL QUALITY ASSURANCE TALLAHASSEE, FLORIDA 32314-6320 DEPARTMENT OF HEALTH LICENSURE SERVICES P.O. BOX 6320

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AC#

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STATE OF FLORIDA DEPARTMENT OF HEALTH DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.	
12/11/1999	ME 14808	17571	

THE MEDICAL DOCTOR
NAMED BELOW HAS MET ALL REQUIREMENTS OF

THE LAWSTAD BOLLS OF THE STATESOF FLOGDING OF THE CONTROL OF THE C

7707 N UNIVERSITY DR SUITE 205 TAMARAC, FL 33321 AT LEAST 90 DAYS PRIOR TO THE EXPIRATION DATE SHOWN ON THIS LICENSE, A NOTICE OF RENEWAL WILL BE SENT TO YOUR LAST KNOWN ADDRESS. IF YOU HAVE NOT RECEIVED YOUR NOTICE 80 DAYS PRIOR TO THE EXPIRATION DATE, PLEASE CALL (850) 410-3359.

COPY - NOT A VALID LICENSE - COPY

EXPIRATION DATE: JANUARY 31, 2002

YOUR LICENSE NUMBER IS ME 14000 PLEASE USE IT IN ALL CORRESPONDENCE WITH YOUR BOARD/COUNCIL EACH LICENSEE IS SOLELY RESPONSIBLE FOR NOTIFYING THE DEPARTMENT IN WRITING OF THE LICENSEE'S CURRENT MAILING ADDRESS. USE THIS SECTION TO REPORT NAME AND/OR MAILING ADDRESS. CHANGES.

NAME CHANGES REQUIRE LEGAL DOCUMENTATION SHOWING THE NAME CHANGE. PLEASE MAKE SURE THAT A PHOTOCOPY OF ONE OF THE FOLLOWING ACCOMPANIES THIS FORM: A MARRIAGE LICENSE (MARRIAGE LICENSE MUST INDICATE THE ORIGINAL SIGNATURE AND SEAL FROM THE CLERK OF THE COURT), A DIVORCE DECREE INDICATING RESTORATION OF YOUR MAIDEN NAME, OR A COURT ORDER (E.G., ADOPTION, NAME CHANGE, OR FEDERAL IDENTITY CHANGE). ANY ONE OF THESE WILL BE ACCEPTED UNLESS THE DEPARTMENT HAS A QUESTION ABOUT THE AUTHENTICITY OF THE DOCUMENT. A DRIVER'S LICENSE OR SOCIAL SECURITY CARD IS NOT CONSIDERED LEGAL DOCUMENTATION.

TO REQUEST A DUPLICATE LICENSE SUBMIT THIS FORM AND A CHECK, PAYABLE TO THE DEPARTMENT OF HEALTH, IN THE AMOUNT OF \$25.00.

REQUEST DUPLICATE LICENSE

SIGNATURE REQUIRED

DEPARTMENT OF HEALTH DIVISION OF MEDICAL QUALITY ASSURANCE LICENSURE SERVICES 2020 CAPITAL CIRCLE, S.E., SIN PC-10

2020 CAPITAL CIRCLE, 8.E., 9IN FC-10 TALLAHASSEE, FLORIDA 32398-3280

ROM:	IAME CHANGE (ATTACH LEGAL DOCUMENTATION)			MAILING ADDRESS CHANGE		
, 100m.	MIDDLE					
TO:						
	LAST	FIRST	MIDDLE	CITY	STATE	ZIP

DH 2103, 5/98

DEPARTMENT OF HEALTH DIVISION OF MEDICAL QUALITY ASSURANCE LICENSURE SERVICES 2028 CAPITAL CIRCLE, S.E., BIN #C-10 TALLAHASSEE, FLORIDA 32399-3280

> MICHAEL J BENJAMIN 7707 N UNIVERSITY DR SUITE 205 TAMARAC, FL 33321

WILL EXPIRE JANUARY 31, 2001937
REMIT FEE OF \$355.00
AFTER EXPIRATION IN INCIDING A STREET OF \$355.00
AFTER EXPIRITY AND INCIDING YOUR MEDICAL DOCTOR LICENSE REMIT FEE OF \$355.00 STATE OF FLORIDA DEPARTMENT OF HEALTH **RENEWAL NOILCE BOARD OF MEDICINE** IMPORTANT: BY SUBMITTING THE APPROPRIATE RENEWAL FEES TO THE DEPARTMENT, A LICENSEE AFFIRMS COMPLIANCE WITH ALL REQUIREMENTS FOR RENEWAL, INCLUDING CONTINUING EDUCATION CREDITS. 4 Middle initial • Please Indicate Maling Address Change Below 7707 N UNIVERSITY DR SUITE 205 Street Address Street Address 見りの MICHAEL J BENJAMIN **TAMARAC, FL 33321** Licensee's Lest Neme Signature: ð

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PAKI B



Jeb Bush Governor

October 18, 1999

Robert G. Brooks, M.D. Secretary

MICHAEL J BENJAMIN, M.D. 7707 N UNIVERSITY DR SUITE 205 TAMARAC, FL-33321

Dear Dr. BENJAMIN

We have not received a response as of September 17, 1999, to a letter we sent to you selding you to verify the correctness of your profiling data which is to be published on the World Wide Web. Please raview the profile information contained in this letter for any changes, conections, and/or omissions to insure the information that will be published is correct. Even if you have no changes, conections, and/or observe and return it to the Department. at Post Office Box 6330, Tallahassee, Florida 32314-6330. If you do have changes, please indicate them directly on this letter. If you do not respond to this request within two weeks of the date of this correspondence your profile will be published as it appears in this letter.

	My	profiling	information	is correct.
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My profiting information is incorrect; changes are noted below.

Practitioner Information

License Number: 14909

Profession

: Medical Doctor

License Statue

: ACTIVE CLEAR

Year Began Practicing:

Primary Business:

7707 N UNIVERSITY DR SUITE 205

TAMARAC FL 33321

Secondary Locations:

Staff Privileges:

The practitioner did not provide this mandatory information.

Faculty Appointments:

The practitioner did not provide this mandatory information.

The practitioner did not provide this mandatory information.

Participates in Medicald Program:

The practitioner did not indicate if he/she participates in the Medicaid program.

Education and Training

320 Capital Circle SE, BIN # C-10 . Tallahassee, FL 32599-3280



Medical School: Dates of Attendance: Graduation Date: Degree Title

The parctitioner failed to provide this mandatory information

Other Health Related Degrees:

The practitioner did not provide this mandatory information.

III. Professional and Postgraduate Training

Program Name: Program Type: Specialty Area: City: State/Country: Dates Attended

The practitioner did not provide this mandatory information.

IV. Specialty

The practitioner did not provide this mandatory information.

V. Optional information

Committees:/Memberships

This practitioner has not indicated any committees on which they serve for any health entity with which they are affiliated.

Professional or Community Service Awards

This practitioner has not provided any professional or community service activities, honors, or awards.

Publications

This practitioner has not provided any publications that he/she authored in peer-reviewed medical literature within the last ten years.

Languages Other Than English

This practitioner has not indicated that any languages other than English are used to communicate with patients, or that any translation service is available for patients, at his/her primary place of practice.

Other Affiliations

This practitioner has not provided any national, state, local, county, or professional affiliations.

E-Mail Address

Not Provided

Other State Licensure

This pracitioner has not indicated any additional state licensure.

VI. Financial Responsibility



I have hospital staff privileges and I have professional liability coverage in an amount not less than \$250,000 per claim, with a minimum annual aggregate of not less than \$300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.367, F. S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance, I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is terminated or that I desire to become uninsured and meet the financial responsibility requirement through other provisions in s. 458.320 or 459,0085, F. S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

Vil. Criminal Offenses

The criminal history information, if any exists, will be incomplete; federal criminal history is not available to the public. The criminal history information provided by the practitioner has not been completely verified at this time. All criminal history checks should be completed by March 2000.

The practitioner did not provide this mandatory information.

VIII. Final Disciplinary Action (Within last 10 years)

Pursuant to section 456.5651(5), F.S. the profile will not include disciplinary action taken by a hospital or ambulatory surgical centers licensed under chapter 395, F.S.

The practitioner did not provide this mandatory information pertaining to final disciplinary action taken by a specialty board within the previous 10 years.

The practitioner did not provide this mandatory information pertaining to final disciplinary action taken by a licensing agency within the previous 10 years.

The practitioner did not provide this mandatory information pertaining to final disciplinary action taken by a health maintenance organization, pre-paid health clinic, nursing home, out-of-state hospital or out-of-state ambulatory surgical center within the previous 10 years.

The practitioner did not provide this mandatory information pertaining to being saked to or allowed to resign from or had any medical staff privileges & restricted or revoked within the previous 10 years.

IX. Liability Claims Exceeding \$5,000.00 (Within last 10 years)

Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment settlement of a medical majoractice action or claim should not be construed as creating a presumption that medical majoractice has occurred.

There have not been any reported liability actions, which are required to be reported under section 455.697, F.S., within the previous 10 years.

If you wish to make changes to the profile after it has been published, please submit them to 2020 Capital Circle SE, Bin # C10, Tallahassee, Florida 32399-6230.

If you have any questions or comments, call (850) 410-3359 Extension 2009.

Sincerely,

Bureau of Operations





MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE

FLORIDA DEPARTMENT OF HEALTH Division of Medical Quality Assurance P. O. Box 6330 Tallahassee, Florida 32314-6330 You the

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If YCS', list all medical-professional schools from which a degree in a health related profession other than the professional degree was obtained. MANE OF SCHOOL / JUNE 1971 1972				•	
MANUEL OF SCHOOL / JAMPSERTY CITY / STORE / COUNTRY MANUEL OF SCHOOL / JAMPSERTY DEBORETITLE	To you currently hold a degree in a heat	th related profession other than the p	rofessional degree listed in '	II. A. above?	Yes 🗀 No 🔀
V. FACILITY APPOINTMENTS: If they you had the responsibility for graduate medical education within the last 10 years? (Authority: a. exc.sec.(1)(o)(a. F.A.) Prise you had the responsibility for graduate medical education within the last 10 years? (Authority: a. exc.sec.(1)(o)(a. F.A.) Prise ? If "YES", to question "B" list the title of the caurant appointment, names) and chlystate of leathfullon(a). IN. STAFF PRIVILEGES: Do you currently hold staff phyllages in a hospital/medical/health institution? Yes \$\frac{\text{S}}{\text{N}}\$ is each hospital/medical/health institut	If "YES", list all medical/professional (Authority: s. 455.565.(1)(a)1., ES.)	schools from which a degree in a he	alth related profession other	r than the professional	degree was obtained.
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Do you currently hold staff privileges in a hospital/medical/health institution? Yes \$ No \\ If "YES", list each hospital/medical/health institution at which you currently have staff privileges. (www.ref. s. 498.986(1)(e)2. E.S.) INVESTIGATION OF THE STATUSES. DO you hold a certification from any specialty board recognized by the Florida board regulating the profession for which you are licensed? Yes \$ 16. "YES", complete section below. SPECIALTY BOARD WARE OFFICIALTY BOARD WARE AND AND DESCRIPTION: AT. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by a specialty board recognized by the American Econo of Medical Specialties, the American Chicopathic Association, the American Chicopathic Association, or other similar mational organization? (www.ref. s. 48.88(1)(e), E.S.) If "YES", list name(s) of specialty loand(s), date, description of violation(s), description of violation(s), description of VIOLATION DESCRIPTION OF PRIAL DISCIPLIBATY ACTION AND DESCRIPTION OF PRIAL DISCIPLIBATY ACTION DESCRIPTION OF PRIAL DISCIPLIBATY ACTION AND DESCRIPTION OF VIOLATION DESCRIPTION OF PRIAL DISCIPLIBATY ACTION AND DESCRIPTION OF VIOLATION DESCRIPTION OF PRIAL DISCIPLIBATY ACTION DESCRIPTION OF VIOLATION DESCRIPTION OF ACTION DESCRIPTION OF ACTION 1. DESCRIPTION OF ACTION	1				UI VAIME
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